

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4708	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During annual Licensure survey conducted on April 14-16, 2013, at Holston Health and Rehabilitation, no deficiencies were cited under 1200-8-6, Standard for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kelsie McLaughlin, Admin*

TITLE

(X5) DATE

4/25/13

STATE FORM

0899

LT5E11

If continuation sheet 1 of 1